

VCRC Service Request Form



VICTORIAN CONTINENCE RESOURCE CENTRE

Date Sent to VCRC:	Completed By:
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Client Details

NAME		GENDER	
ADDRESS			
Is this a Supported Accommodation Residence?		SRS / SDA / OTHER	
D.O.B		NDIS PLAN #	
PHONE		EMAIL	

Referral By: Support Coordinator / House Support / Next of Kin / POA

NAME			
ORGANISATION			
MOBILE		OFFICE PHONE	
EMAIL			
RELATIONSHIP			

Continence Service Requested: Continence Nursing Physiotherapy Catheter Change

Reasons for Assessment:

- Bladder/ Bowels NDIS Reporting Purposes Products Review / Recommendation
- Advice/Education Bed Wetting Toilet Training (Need 6+ hours funding)
- Condom Drainage/Training Pelvic Floor Physiotherapy Nurse Assisted Training (Check funding)

Appointment Details:

- Requires Interpreter - Language Requested _____
- In Clinic Phone Video/FaceTime External (by approval) Review/Follow Up

Disability Details:

- Physical Neurological Behavioural Concern Intell/Dev ASD Mental Health
- Non-verbal Spina Bifida Prostate Down Syndrome Other _____

Mobility Aids:

- Wheelchair Mobility Scooter Frame Walking Stick Other _____

MEDICAL NOTES HERE:

Payment Details:

- NDIS Portal Claim INVOICE to a Financial Plan Manager PayPal/Cash (Self-Managed Plans)

Plan Manager Invoice EMAIL & Phone _____